SHICK Senior Health Insurance Counseling for Kansas

For Agency use only	
SO	
Full	C/D only

2015 SHICK Counselor Training Record

Training Date: _____ **City:** _____

PLEASE PRINT (Most SHICK information & correspondence is sent via E-mail. **An E-mail address is REQUIRED!)**

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ County: _____

Telephone No: _____ E-Mail (required) _____

Company (if applicable): _____

Primary address: **Home** ❑ **Work** ❑

Status

(Mark only one)

❑ Volunteer *(Unpaid)* For Agency: _____

❑ Partner *(Paid staff for SHICK partner)* Employer's Name: _____

Gender/Age

❑ Female ❑ Male

Date of Birth: _____ ❑ Not Collected

Ethnicity/Race

❑ Hispanic, Latino, or Spanish Origin
❑ White, Non-Hispanic
❑ Black, African American
❑ American Indian or Alaska Native
❑ Asian Indian
❑ Chinese
❑ Filipino
❑ Japanese
❑ Korean
❑ Vietnamese
❑ Native Hawaiian
❑ Guamanian or Chamorro
❑ Samoan
❑ Other Asian
❑ Other Pacific Islander
❑ Some Other Race-Ethnicity
❑ More Than One Race-Ethnicity
❑ Not Collected

Disability Status

❑ Disabled
❑ Not Disabled
❑ Not Collected

Languages

Do you speak a language other than English? ❑ Yes ❑ No

If yes, please list other language(s) _____

We will only use your personal information to contact you with requests or information you'll need as a SHICK volunteer. We won't share your contact information outside the SHICK program without your permission, unless we're obligated by law to disclose it.

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Optional

Do you have any medical conditions you would like SHICK to be aware of? ❑ Yes ❑ No

If yes, please describe: _____

Do you require any special accommodations? ❑ Yes ❑ No

If yes, please describe: _____

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SHICK Senior Health Insurance Counseling for Kansas

MEMORANDUM OF UNDERSTANDING
REGARDING
COUNSELOR RESPONSIBILITIES AND OBLIGATIONS

As a certified Counselor in the *Senior Health Insurance Counseling for Kansas Program,* I agree to follow all program guidelines and regulations. Neither the Senior Health Insurance Counseling for Kansas Program nor the Sponsoring Organization is responsible for my activities or responsibilities other than those stated in these program guidelines. Any action beyond those covered in the guidelines will be taken at my personal risk.

1. NATURE OF SERVICE

I understand that my basic responsibilities as a Counselor include providing accurate, objective, unbiased counseling and assistance with Medicare, health insurance, and related health coverage plans for Medicare beneficiaries, their representatives or persons soon to be eligible for Medicare, and educating the public on Medicare and health insurance issues that affect older citizens. I agree to take the Initial Training Certification and participate in Update Training as required under this program. I understand that I may conduct counseling sessions at specified counseling sites, by telephone, or at clients' homes if their health conditions require. I agree to complete the Client Contact Forms and to submit them each month.

2. CONFIDENTIALITY

It is understood that in the performance of my duties, I will have access to certain sensitive information about the client, and that such information may include medical, insurance, financial and other personal and confidential data. I agree to restrict my use of such information to the performance of my counseling duties described in the program guidelines and understand that there is to be no discussion of cases or mentioning of clients' names except when in direct contact with Medicare, insurance companies, providers of medical services/supplies, and/or members of the Senior Health Insurance Counseling for Kansas program staff.

3. CONFLICT OF INTEREST

The Senior Health Insurance Counseling for Kansas Program requires that counselors shall not promote private or personal interests in conjunction with the performance of duties covered in the state program guidelines. To comply with these requirements, I agree to the following:

A. I will in no way attempt to conduct market research or solicit, persuade, or coerce clients to purchase a specific type of medical insurance coverage, to convert an existing policy to another carrier, to go to a specific provider of service for treatment, or to direct a client to a specific agent/broker or any profit-based billing service. **I understand that this means that neither I nor a member of my immediate family may be currently in the business of health insurance.**
B. I will not disclose nor use confidential information obtained as a result of my association with or access to any client for personal gain or advantage for my employer or any other parties.

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4. ACKNOWLEDGMENT

I hereby acknowledge my obligation to respect the confidentiality of the client and to exercise good faith and integrity in all dealings with the client in the performance of my duties as a Certified Counselor in the Senior Health Insurance Counseling for Kansas program. I have received training in privacy issues and protecting client confidentiality as well as the use of the SHIP Unique ID. I understand that a breach of confidentiality or conflict of interest will make me personally liable for my actions regarding the client's right to privacy and confidentiality, and could be grounds for de-certification as a Counselor.

_____

Name of Volunteer/Partner (*Please Print*)

_____

Volunteer's/Partner's Signature Date

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